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HOME HEALTH CARE FOR THE ELDERLY: SYRACUSE, NY

COMPLETED ORIGINAL

H47p

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

FEBRUARY 14, 1986, SYRACUSE, NY

Comm. Pub. No. 99-557

Printed for the use of the Select Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1986

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HOME HEALTH CARE FOR THE ELDERLY: SYRACUSE, NY

FRIDAY, FEBRUARY 14, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Syracuse, NY.

The committee met, pursuant to notice at 1:10 p.m., in the Upstate Medical Center, Weiskotten Hall, Irving Ave., Syracuse, NY, Hon. George C. Wortley (acting chairman of the committee) presiding.

OPENING STATEMENT OF REPRESENTATIVE GEORGE C. WORTLEY

Mr. WORTLEY. Good afternoon, ladies and gentlemen.

I would like to take this opportunity to welcome you to the United States House of Representatives' Select Committee on Aging field hearing. The topic is home health care and I hereby convene this session to order.

Before we begin, Congressman Biaggi of New York City, who was scheduled to be my associate in the hearing, has had a complication arise and is unable to be present. He has sent me a telegram and I will read the first paragraph for the record and we will insert the balance in the record of today's session [reading]:

STATEMENT OF REPRESENTATIVE MARIO BIAGGI

Dear Friends: I deeply regret that commitments in my congressional district will prevent me from participating in this important hearing on home health care services for the elderly. I wish to commend my good friend, George Wortley, not only for scheduling this hearing, but also for his tremendous commitment to the elderly which he has shown time and time again as a key member of the Subcommittee on Health and Long Term Care of the House Select Committee on Aging.

Home health care in our Nation needs greater support. Medicare and Medicaid, which are the largest and most important Federal health programs for the elderly, show a pronounced bias in favor of providing change in this priority. It is time to expand Medicare coverage to include more home health care services. It is time for the administration to stop trying to increase the copayments for these services. It is time to renew and expand the so-called Medicaid waiver programs which provide help for programs providing alternatives to institutionalization, including home health care.

Finally, it is vital that we continue to provide adequate support for home-based programs which help the 'at risk elderly' population, most especially, the nutrition programs provided by the Older Americans Act. The Home Delivered Meals Program under the act is of special importance to the elderly of New York State, especially Syracuse. It provides one hot meal a day, 5 or 7 days a week, for homebound seniors. For many of them, it keeps them out of institutions.

I hope this hearing will provide us with findings and recommendations that can be put into policy. The year ahead will be pivotal not only for home health care, but many other issues related to the elderly. We are simply going to have to do more

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with less. Those programs that are cost effective should and will get more favorable attention. It is time home health care was recognized not only as the humane alternative to institutionalization, but also as a cost-effective alternative.

Mr. WORTLEY. Home health care is a service that provides a very positive alternative to the nursing home option. While not all elderly people are able to remain at home with some supervision, there are a number of programs that we will hear about today that offer varying degrees of assistance to families who opt for their type of care.

Today we will hear from many experts in this field in two panels. Following the testimony, there will be an opportunity for questions from the audience followed by an informal reception at the end.

Members of my staff from both Washington and Syracuse are here today to assist you in any way possible following the hearing.

I thank all of you for attending and the witnesses for taking time out of their busy schedules to help us better understand home health care.

With me today is my staff assistant, Martha Carmen, who handles all of my legislative relationships as they pertain to senior citizens and health care.

Seated behind me is Loretta Toppe of our district staff, who will be here at the end of this hearing and will be available if you have specific problems you would like to address to her.

Today we are in the County of Onondaga, a county that is deeply concerned about its elderly. With us is Linda Clifton, the administrator of human services of Onondaga County representing the county executive, John Mulroy.

Linda, welcome. Do you have some comments?

STATEMENT OF LINDA CLIFTON, ADMINISTRATOR, HUMAN SERVICES, ONONDAGA COUNTY, ON BEHALF OF COUNTY EXECUTIVE JOHN MULROY

Mrs. CLIFTON. I am pleased to welcome you to the home health care hearing. On behalf of the county executive, John Mulroy, I express our appreciation to Congressman Wortley and to the Select Committee on the Aging for making the hearing possible.

As we are all aware, there have been dramatic changes in trends in the health care delivery system. Many of these changes have been difficult and they certainly have been challenging. All of our communities across the nation face these difficult experiences.

With the increased numbers and emphasis on ability to treat and prevent illnesses and injury, there has been a dramatic shift in health care. It has shifted away from the acute hospital care to long-term health care.

With the rising medical costs and the strict controls on utilization of hospital beds and services, long-term health care has gained new stature and it has become an integral part of the home health care system.

In response to that, in our county, we created the Department of Long Term Care. That combined our county nursing home with the county public health nursing department for home care. Therefore, we will now have the emphasis on the whole continuum of care.

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In addition, we have the long-term health care program or the nursing home without Walls instituted in 1977 and this provides a coordinated array of services to our failing elderly who want to remain in the home.

Our home health care is quickly becoming a choice of the new generation who are seeking quality and dignity for themselves, their parents and their children. We have been extremely proud of our achievements in the area of home care. More and more of our elderly and infirmed are operating to remain in the comfort of their homes, but they do continue to require other services. Our home health care is a priority. We know we have many of the services, but we also know there are many things that we don't have. We know that we need to have more supports for families who do provide the long-term care. We know that we need a more coordinated system and we know that we need to have a system that allows access at any one point for the elderly or the infirm, so I am here to learn also and the county welcomes you and hopes that all the information is valuable to us.

Mr. WORTLEY. Thank you very much, Mrs. Clifton.

We are happy to be in Onondaga county today. As you well know, the purpose of these hearings is to get things on the record. The U.S. Congress, the Department of Health and Human Services, all recognize the high cost of health care. There is a vital need for services, particularly for our elderly, and when we go out into the field to hold these hearings, this is our opportunity to find out what the feeling is back where the real needs are.

Unfortunately, the folks from back home cannot always go to Washington and have their voice heard and this is an opportunity for Washington to come to Syracuse in this particular case and listen to the needs and concerns of the people. Our first panel of experts this afternoon, I start out at my far right, Mrs. Marilyn Wurzburger of the St. Camillus Home Health Care Agency.

The second panelist will be Al Cardillo of the Health Care Staff of State Senator Tarky Lombardi.

The third member of the panel is Charles Conole, vice president for patient services at Crouse-Irving Memorial Hospital

The fourth panelist will be David Davin, M.D., a physician with a lot of experience in helping families make the transition when leaving the hospital, and the fifth panelist will be Myron Miller, M.D., representing the State University of New York Health Science Center.

Doctor, in welcoming all the panelists, particularly you, thank you for the utilization of your facility here. This is another example of governments working together. We have representatives on this panel who are from another level of government, myself in particular from Washington, and it is only by all levels of government working as a partnership, working together, not working at distant polls, but working together that we will achieve success in bringing the best possible health care to the older American citizen.

So without further ado, I am pleased to ask Mrs. Wurzburger if she would like to begin. Your prepared statement will be entered in the final testimony of this hearing and if any of you wish to summarize your comments, you may feel free to do so.

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Thank you.
Mrs. Wurzburger.

STATEMENT OF MARILYN A. WURZBURGER, DIRECTOR OF PATIENT SERVICES, ST. CAMILLUS HOME CARE AGENCY

Mrs. WURZBURGER. Home care is now being looked at first as a viable delivery system of health care rather than being removed from the mainstream of the health care industry as has been in the past.

Rapid changes and growth in home care are occurring largely as a result of policy changes designed to curtail costs to other parts of the health care system. The recently enacted initiatives to decrease the use of institutions will require increased use of efficient and creative community and home care options if people are going to receive needed care in the most cost-effective settings. These incentives which are driving the growth of home care include the introduction of DRG's and New York State's plan to decrease hospital beds by 25 percent by 1990. There is a definite need to support and develop innovative programs and services which can provide new approaches to community needs as they are identified.

Some of these incentives that are needed are demonstration projects and money for grants.

The St. Camillus Home Care Program has been in operation for 2 years. It is relatively new in this area. It came into being as a natural extension of both inpatient and outpatient services provided by St. Camillus Residential Health Care Facility. It is one of the first skilled nursing facility-based certified home care agencies in New York State.

The Home Care Program offers the individual an opportunity for continuity of care as their circumstances and condition changes. A multidisciplinary team approach is used with the community health nurse acting as coordinator with weekly team meetings to develop an individual care plan for the patient which the physician adds to and approves. The services available through the Home Care Agency include nursing, home health aid, physical therapy, occupational therapy, speech therapy and audiology, nutrition counseling, medical social service counseling, respiratory therapy, durable medical equipment and supplies, pharmaceutical services, and EKG.

The emphasis is placed on developing a plan of care which actively involves the patient and family in intensive rehabilitation thus promoting earlier discharge from a long-term care facility or avoiding any facility admission entirely by providing the same intensity of service at home. The area of services is all of Onondaga County and referral sources include hospitals, physicians, patient and family, self-referral and other long-term facilities.

To give you an example in the rehabilitative approach to the elderly persons, small gains in function are of a lot of importance. Small gains can make all the difference in the degree of independence that a person can achieve. A simple example, say, would be that if an individual can acquire the ability to transfer without assistance from bed to chair, from bed to camode or to wheelchair and a person recovering from a stroke, this ability to give that

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person the independence that they would need in carrying out most of the activities of daily living, even if this person was not able to walk and did require a wheelchair for locomotion.

We consider the Home Care Agency is the formal support system and works with the care-giving family and friends who constitute a vast resource of the informal support. This informal support system is a fragile one subject to threats from many areas such as economic threats or illness of the caregiver.

By its presence and services, the home care agency strengthens and supplements this family care unit and helps the dependent member move forward to independence. How much more society is willing to give to families to sustain the care they provide to dependent individuals and in what form is clearly at this time a political issue.

Present payment sources can render home care difficult to obtain and maintain for the agency. The Office of Management and Budget has a concern that the growing demand for home care will be additive rather than in place of institutionalization and fear that the cost to government programs will increase dramatically if they ever allow it to gain momentum.

This feeling is reflected by a series of administrative edicts by Health Care Financing Administration which are restrictive to Medicare payments for home health while greater numbers of sicker patients are being discharged quicker. Medicare has not expanded its commitment to reimbursement of the services of home health agencies. The effort of providers to comply with the time restraints of "covered care" and to meet the individual needs of the very ill, elderly person in some instances leaves little opportunity to really get the individual stabilized.

When home care services are maximized in our program, we attempt to utilize some of the other services such as the Day Care Program and the outpatient services including comprehensive outpatient rehabilitation facility in order to provide ongoing case management and support. The community resources such as Meals-on-Wheels Program and respite services are also utilized in order to avoid as much fragmentation of services as possible.

Medicare has proposed copayment for home care services in the past and this proposal is also to be included again in the 1987 Federal budget. This proposal would establish a copayment equal to 1 percent of the inpatient hospital deductible—$572. This would apply to all home health visits except those following an inpatient hospital or skilled nursing facility stay for a condition treated in the hospital. This will discourage the sick elderly from receiving home care services plus add administrative costs to home care providers in trying to collect the copayment.

In conclusion, home care is the oldest form of health care. Health care has been traditionally given at home throughout the centuries. But paradoxically, it is also the newest modern technology has developed to the point where many services heretofore only available in hospitals can be provided at home.

There is significant evidence that it is less costly than other forms of care and that it is the most satisfying form of health care available to the American public. Studies done by the National Association for Home Care show that as the public becomes aware of

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home care, it is their overwhelming preference of health delivery. It is a health care concept whose time has come—being driven by powerful forces—tradition, technology, demographics, public demand, and public policy.

It behooves all providers to respond to these forces by continuing to give quality care and to develop new programs and services to meet this need. This has to be done by a cooperative effort between providers of home care, other health care providers, community agencies, and policymakers.

This hearing and a meeting this morning of the Planning Committee of the Metropolitan Commission on Aging to which the providers of certified home services were invited, are examples of the community responding and attempting to provide some answers.

Thank you.

Mr. WORTLEY. Thank you very much.

Our next panelist is Al Cardillo.

Mr. CARDILLO. Thank you.

Mr. WORTLEY. We will reserve questions until all the panelists have completed.

STATEMENT OF AL CARDILLO, HEALTH CARE STAFF OF STATE SENATOR TARKY LOMBARDI

Mr. CARDILLO. Thank you. Good afternoon

I am Al Cardillo, long-term care specialist on the staff of the New York State Senate Health Committee here to represent Senator Tarky Lombardi, Jr., the New York State Senator from this district who I am sure you are all familiar with.

Senator Lombardi is chairman of the State Senate Committee on Health as well as chairman of the State Council on Health Care Financing. He is sorry that a previous commitment precluded his being here and has asked me to speak on his behalf to you, Congressman Wortley, and the House Select Committee on Aging regarding home health care in New York State.

Your hearing on this crucial area of our health care delivery system, which is of particular importance to the aged, is indeed most timely and relevant.

This is a time of great change and shifting emphasis in the health care delivery system. The focus continues to shift from the once nearly sole reliance on the institutional care system to an ever increasing emphasis on providing care at home. This changing emphasis has resulted largely from the increases in demand and the extreme costs of acute and long-term care. The trend during the sixties and the seventies of building more institutions has given way to initiatives aimed at decreasing institutional use and facilitating care of patients in their own homes.

Home health care, for the vast majority of patients, has proven to be a preferable and less costly means of delivering needed services. It has emerged as the primary policy and clinical focus to meet our current and future health care needs.

New York State continues to be fully committed to its home care program. We have developed the most comprehensive home care continuum in the Nation. We have 130 certified home health agencies providing nursing, therapeutic and aid level care. Our nursing

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home without walls program, which currently has 86 providers across the State, 3 here in Onondaga County, provides nursing home eligible patients with comprehensive, coordinated long-term care in their own homes.

A personal care program, available in nearly all 62 counties, provides patients with basic personal and household support services. These programs are complimented by a range of other services and initiatives provided through our State and community agencies which further assist in meeting patients' needs at home.

Until recently, proprietary agencies were precluded from participating as Medicare and Medicaid providers of home health care services. For-profit home health agencies have now been brought into the State's regulatory system and are accepted in the Medicare and Medicaid Programs.

With this change in New York State's law, along with the anticipated expansion of home health agencies to respond to the ever-increasing needs, it has been necessary to revise and significantly strengthen the regulations and standards for patient care and management.

Generally, New York State's experiences with home health care have been positive. While providing quality care to patients at home, our home care programs have reduced reliance on the institutional system and have been an instrumental part of the State's health care cost containment efforts.

We are especially pleased with the success of our Nursing Home Without Walls Program, New York State's primary alternative to long-term institutionalization. This program has proven to be the most viable alternative for patients who prefer to remain in their own homes rather than enter long-term care facilities. Its cost savings potential has been well demonstrated for both public and private payors.

I would like to specifically focus on our experienced with this important, unique program.

The Nursing Home Without Walls Program is exactly as its name describes—nursing home level care is offered to patients in their own homes rather than in a facility. Nursing Home Without Walls provides each patient with a comprehensive, coordinated program of long-term care, managed around the clock and custom-tailored to meet their specific health, social, and environmental needs at home.

Patients are not provided with extra or unnecessary services nor must they fit into a fixed care pattern or the day-to-day routine of facilities. The program is available to any patient who is determined medically eligible for care in a residental health care facility and who has a suitable home in which to receive services.

Nursing Home Without Walls may be provided by hospitals, residential health care facilities and certified home health agencies.

Senator Lombardi developed the Nursing Home Without Walls Program in 1977 largely because the reimbursement mechanisms and the lack of adequate community services were causing premature and unnecessary institutionalization of patients who could be and preferred to be cared for at home. The program began operation in 1978. After a relatively slow startup, it has grown significantly with approved providers in nearly all areas of the State. Its

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current caseload is about 4,000 patients and is increasing all the time.

The program has proven to be a real cost-saver. Although each patient's care cost is capped at 75 percent of the local skilled nursing or health-related facility rate, whichever is appropriate for the patient, average costs have consistently been below the cap and have stayed at about half the cost of long-term institutional care.

Nearly two-thirds of the patients require skilled level care; almost half of all patients in the program live alone. This is testimony to the ability and motivation of even the very sick and those who live alone to remain in their own homes given the appropriate care and support.

Through Nursing Home Without Walls these patients, who would have otherwise been institutionalized, have been stabilized and cared for at home in their own familiar, personal environments.

Not only has institutionalization been totally avoided or, for some patients, at least delayed, but patients have actually been returned to their homes from long-term care facilities. Many patients have been afforded the opportunity to die at home with dignity surrounded by their families. The social and fiscal benefits to patients, families, and communities have been great.

I wish we had the time to fully discuss the program's benefits through descriptions of the patients themselves, who have been so satisfied with this service and well cared for and supported through the program. Nursing Home Without Walls is Senator Lombardi's proudest accomplishment and he has every reason to be proud of the program.

Although New York's home care programs have provided essential care and support for our ill and infirm aged, and we have come a long way, there still remains a significant need for improvement and expansion. Although we are committed to bringing about changes and improvements necessary to assure proper care and access for those in need, support at the Federal level is equally crucial.

There continues to be wide gaps and an institutional bias in the public and private financing mechanisms. Neither Medicare nor private health insurers cover the extreme, ongoing costs for long-term care nor do they completely meet patients' needs at home.

Medicaid eligibility standards require persons to spend their lifelong savings and most of their income before they are eligible for coverage. Because of the tremendous expense of long-term care services, as well as the gaps and limitations in coverage, middle-income people who have saved and wisely invested during their working years face impoverishment should they experience catastrophic or chronic illness.

The system unfairly penalizes our aged for the ills and infirmities which are a part of growing old. At a time when they are most physically and financially vulnerable, patients and their spouses are forced into a serious dilemma: should they impoverish themselves and enter institutions in order to obtain care and coverage, or should they struggle at home without appropriate care and supports.

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Efforts must be directed at making the public and private financing mechansism more flexible in order to assure adequate coverage for our aged in need of health care and supports at home.

Senator Lombardi has several proposals and programs which address the issues of impoverishment and needed flexibility in coverage. One of our initiatives, which was enacted as part of a comprehensive Medicaid reform law of 1984, will soon be underway on a demonstration basis.

It authorizes use of alternate eligibility standards for elderly patients to reduce the extent to which their spouses must impoverish themselves in order to receive Medicaid coverage for care at home.

Of the six districts involved in the demonstration, five target elderly patients on hospital alternate level of care status to facilitate discharge and more appropriate care at home; the sixth targets hospital patients as well as those in the community.

Last year we enacted legislation to establish a home health grant program which should help fill some of the gaps. This program will assist certified agencies to care for those who are unable to pay, those in isolated rural or inner city areas and those with intensive/high cost care needs.

Another initiative would implement, on a demonstration basis in up to six local districts, a catastrophic health care expense program which Senator Lombardi established in 1978 but which has never been implemented due to the lack of Federal financial participation.

This program would provide coverage, on a cost-sharing basis, to persons incurring catastrophic health expenses without requiring them to first spend down to the Medicaid level. The program would cover all but long-term institutional care. Hopefully with the current Federal interest in this area, this initiative can be favorably considered and finally implemented.

We are particularly heartened by President Reagan's interest and Health and Human Service Secretary Bowen's recommendations to extend Medicare to cover catastrophic costs. Senator Lombardi urges the Federal Government to participate in New York State's catastrophic demonstration plan. It is viable, effective, and workable.

In addition, he fully supports the extension of Medicare in accordance with the Secretary's recommendations and hopes that enabling legislation will be introduced and acted on favorably by Congress.

We must continue to direct our efforts toward these and other sound initiatives to enhance public and private coverage for care of the aged and infirm.

With the implementation of the Medicare prospective payment system for inpatient hospital care in New York this year, we anticipate the earlier discharge of hospital patients who will require continued care upon return to their homes. This will require an increase in the existing home health care capacity in order to meet the increases in patient need.

Given the increase in patients requiring more intensive and more complex care at home as well as the need for increases in our home health capacity, there must be an adequate supply of appropriately trained, quality home care workers.

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If reliance on the institutional care system is to be reduced, if home care is to expand in order to meet the increases in patient needs and if quality and access are to be assured, then the required manpower and service to provide this care must be assured as well.

Adequate housing is also of prime importance. Programs to assist with the housing, residential, and retirement needs of our aged are crucial in keeping persons out of institutions and in the community.

These are just a few of the many issues and concerns in home health care which demand our focus. Although we have come a long way, there is still much to do. We must continue to expand and enhance the programs which provide effective, efficient care at home.

We must also have new and flexible initiatives to fill gaps, further contain costs and assure access to and delivery of our home health care services.

Senator Lombardis is committed to this effort and hopes that the Federal Government will also act to assure that the needs of the aged are recognized and appropriately addressed.

Senator Lombardi sends his thanks to you for inviting us to testify before you today. He congratulates you for holding this hearing and wishes you and your Select Committee on Aging much success in your efforts to assure appropriate, quality care to our senior citizens.

Thank you for your attention.

Mr. WORTLEY. Thank you, Mr. Cardillo.

[Additional statements submitted by Mr. Cardillo follow:]

PREPARED STATEMENT OF JANET E. STARR, EXECUTIVE DIRECTOR, HOME CARE ASSOCIATION OF NEW YORK STATE, INC.

I am Janet E. Starr, Executive Director, Home Care Association of New York State, Inc., with offices at 840 James Street, Syracuse, New York. I appreciate the opportunity to present this statement for the hearing record. I regret that a prior commitment of long standing prevents me from presenting this statement in person.

The Home Care Association (HCA) is a non-profit statewide organization composed of providers of home care services, allied organizations, and individuals. As the major spokesman for home care in New York State, HCA's concern is the orderly development of home care services of assured quality which are sufficient for the needs of those who should receive this care. HCA advocates a system which ensures equitable access to the home care services needed by the individual, regardless of age, ability to pay or area of residence. HCA also advocates a system which requires compliance with common basic standards which will result in safe care.

Home care promotes independence through the provision of health and related services to individuals in their own homes. Care at home enhances the quality of life in the community and also supplements and reinforces care given by family and friends. Home care can be an effective substitute for prolonged hospital or nursing home care by providing health and social benefits not otherwise obtainable. It can provide short term care at home for an ill person released from the hospital after as short a stay as possible. Or, it can provide long term care to persons with chronic illness or mental disabilities.

The key home care services needed by elderly Americans are nursing, therapies (physical, occupational, speech), social work and homemaker/home health aide/personal care services.

While home care is needed and used by persons of all ages, the majority of persons served are elderly. The statistics on the greying of our population are well known to the Committee. The increased number of persons living to an age at which they require health care from other than family members is leading to larger outlays for Medicare and Medicaid, especially for institutional care. In these circumstances home care has an increasingly larger role to play. Home care can substitute for more costly hospital and nursing home care, or it can postpone or delay it. Used

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in this way, home care can help slow the rise in health care expenditures, as well as safeguard maximum independence and self-determination for the elderly.

Prompt action in Washington is needed in two critical areas if this capability of home care is to be maintained and improved so elderly persons may receive the care they need in the appropriate setting:

1. Halt the erosion of the Medicare home health benefit.
2. Make long term care available to elderly persons in their homes.

EROSION OF THE MEDICARE BENEFIT

The Medicare home health benefit is being eroded seriously by recent short-sighted actions in Washington.

Medicare places limits on the amount it will pay for each home care service delivered to the beneficiary. These limits are now applied in the aggregate so that on the average an agency's costs are within the limits. New Medicare cost limits effective last July will be applied separately to the costs of each type of service provided by the home health agency. What does this mean to elderly Medicare beneficiaries? It means that these services may be rationed or unavailable in some localities. Therapies, such as physical therapy, and home health aide service are the services most in jeopardy. These services are more important than ever as New York State hospitals go to a DRG system (reimbursement based on diagnostic groupings) for Medicare patients which causes patients to be released from the hospital "quicker and sicker" and thus more in need of these very services than ever before.

We urge the Committee to introduce and actively support legislation to permit the Medicare cost limits to be applied in the aggregate, rather than by discipline or type of service. Such legislation is essential if home health agencies are to have available the range of services covered by the Medicare home health benefit.

Another erosion: The Administration wishes to abolish the waiver of presumptive liability granted to home health agencies. The waiver was designed to ensure continuity of care as a patient moves from the hospital to home. The waiver permits an agency to begin home care services without delay following hospitalization, or to prevent admission to a hospital, pending Medicare approval. If the patient is determined not to be covered for the services initially provided, Medicare will pay for them as long as such claims amount to no more than two precent of total agency claims. Without the waiver, the patient would have to pay for the initial services, or the agency would have to absorb the cost. Patients and agencies cannot afford to do this.

Congressman Edward Roybal, Chairman of the House Select Committee on Aging, has introduced H.R. 4065 to continue the Medicare waiver of liability presumption for home health agencies and skilled nursing facilities. We strongly support this bill and urge its prompt passage. It is essential for continued timely and appropriate response to the home care needs of the elderly under the Medicare program.

An Administration budget proposal calls for beneficiaries to pay $5 a visit after 100 home care visits in a calendar year. This copayment is a further erosion of the Medicare home care benefit. A similar proposal was defeated last year after Congress heard from constituents of the hardships this would cause. This copayment would be a disincentive for the use of the Medicare home health benefit by beneficiaries with a valid need for care at home. Savings would not be significant. In fact, projected savings easily could be wiped out by increased costs of administration. We strongly urge that this proposal be discarded or defeated.

LONG TERM CARE FOR ELDERLY PERSONS AT HOME

The other serious home care problem facing elderly Americans is the need for coverage for long term care at home. Medicare covers home health care only until a patient's condition has been stabilized. It does not cover long term care for chronic, stabilized conditions. As you know, the costs of obtaining needed long term care can be a catastrophic cost for many elderly persons. I know that this Committee already is investigating how to finance long term care for the Medicare population.

I commend to your attention New York State's innovative Long Term Home Health Care Program. The program, also known as the Nursing Home Without Walls, is the result of legislation developed by Senator Tarky Lombardi Jr., Chairman of the New York State Senate Health Committee. This program provides a coordinated package of services to patients whose needs qualify them for placement in a skilled nursing home or a health related facility as long as the costs of the home care services provided will be no more than 75 percent of the cost of the institutional care that otherwise would be required.

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Patients on the program are cared for at home for 50 percent, on the average, of the cost of institutional care. The program has proven its worth and cost effectiveness and soon will be available in all parts of the State. The State has modified its certificate of need methodology for residential health care facilities by substituting "slots" in the Long Term Home Health Care Program for some of the beds for which a need can be proven.

The Program has a controlled capacity as well as controlled costs. It merits close examination and consideration for inclusion in any extension of the Medicare program to meet the long term care needs of beneficiaries, perhaps in conjunction with a new Medicare long term care insurance program.

We appreciate the opportunity to bring these concerns and suggestions to your attention. Thank you.

PREPARED STATEMENT OF VIRGINIA ATTRIDGE, EXECUTIVE DIRECTOR, HOME AIDES OF CENTRAL NEW YORK, INC.

During 20 years of providing service to area residents, Home Aides of Central New York, Inc. has been witness to many changes in the field of home health care. Many of these changes have required the agency to be highly flexible, in order to meet community needs.

In the past few years, changes in the field of home care have been made at the expense of the elderly. The large majority of people receiving home care services are frail elderly, yet cutbacks in the hours of home health service reimbursed by Medicare, and the establishment of DRG's target that population. Elderly patients are discharged from hospitals early, yet reimbursement mechanisms severely limit the services that can be delivered to the patients in their own home.

We recognize the validity of the two objectives—adequate service for persons in need, and cost containment—but feel strongly that without careful monitoring, and increased flexibility in the ability to provide care, the first objective will be cancelled out by overconcentration in the second.

PREPARED STATEMENT OF ROBERT SHAW, CHAIRMAN OF MADISON COUNTY R.S.V.P. ADVISORY COUNCIL

During recent confirmation hearings before the United States Senate, Dr. Otis Bowen, the new Secretary of the Department of Health and Human Services, proposed that Medicare be expanded to cover cost of catastrophic illnesses and long-term care. Improved home health-care provisions under Medicare would lengthen the timespan for many seniors to remain in their own homes.

Our present situation wherein seniors are forced to deplete their resources to the tune of $3,000 or more a month to enter a nursing home is disgraceful!

STATEMENT OF CHARLES CONOLE, VICE PRESIDENT FOR PATIENT SERVICES AT CROUSE IRVING MEMORIAL HOSPITAL

Mr. WORTLEY. Mr. Conole.

Mr. CONOLE. Thank you, Congressman.

My experience with home health care services dates back in the early 1970's when I was a member of the Syracuse Hospital Council, the predecessor to the Hospital Executive Council. A task force was formed to look at the need to provide improved home care services at the time of discharge from the hospital. This task force consisted of the late Sister Wilhelmina, administrator of St. Joseph's Hospital; Amelia Greiner and Marty Duggan, consumer representatives from the Comprehensive Health Planning Agency, the predecessor to the current Health Systems Agency; and Audrey Byrnes, representing the health department.

From this task force, two primary goals were identified: One, the Visiting Nurse Association [VNA] and the county health department should provide a full-time representative at each of the four acute care hospitals to help expedite appropriate patient placement for home care services; two, a centralized patient placement proc-

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ess should be coordinated through the Visiting Nurse Association for long-term care placement.

The first recommendation, regarding the placement of a VNA and/or health department representative in the hospital, has been in effect for well over 12 years. Unfortunately, the second recommendation was never successful as each of the hospitals had a strong preference to maintain their individual negotiations as to placement of the alternate care patient with a respective nursing home.

Despite the worthy efforts of this initial task force on home care, there continued to be active discussions through the 1970's within planning agencies and the local hospital council regarding improved discharge planning and the severe shortage of nursing home beds. To address this need, the health planning agency approved and implemented the addition of 360 long-term care beds for Onondaga County within the past 5 years.

This significant increase in long-term care beds, however, has not alleviated the concern by county legislators for the need to build more beds. They have also expressed concern that home care is not a viable alternative for the elderly and, in essence, is ineffective.

From my perspective, let me state quite frankly that we would have a far greater crisis regarding the alternate care patient if we did not have viable home care programs, such as the Visiting Nurse Association, within this community.

Currently, within the Syracuse hospitals, we have 120 patients awaiting placement to nursing homes. At the same time, Crouse Irving Memorial Hospital averages about 200 patients per month who are discharged to home care services. Over the past 2 years, the discharge planning to home care services has increased approximately 10 percent each year.

Despite the efforts of the hospital's social service staff and the Visiting Nurses Association to discharge patients in a more expeditious fashion and the efforts of the Visiting Nurse Association assisting us in meeting this need, we are confronted in 1986 with decreased pressure to shorten the length of stay because of the new Federal Medicare Perspective Payment System—Diagnostic Related Groups. With DRG's, there is now even greater incentive for us to continuously look for ways to discharge the patient from the hospital as soon as possible.

In the fall of 1985, Crouse Irving Memorial Hospital submitted a certificate of need application to meet the community need for high-tech services within the home care field. Specifically, I refer to parenteral nutrition and/or other IV support services, chemotherapy, respiratory therapy, high-tech infant support services, and pediatric rehabilitation.

In the interim, we are working closely with St. Camillus' Home Health Care Program to serve our patients' needs. If Loretto Geriatric Center, St. Camillus, and the Visiting Nurse Association can meet our needs, I foresee no need to pursue our application in the high-tech areas. However, if these needs are not appropriately addressed, we will follow through with the request for approval of our application at the local, regional, and State level.

In summary, I feel it is important for me to address, from my perspective, the barriers to home health care services. If a home

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care service is to be successful, it must have a "significant other" at home to provide the majority of care. I refer each of you to a recent article in the New York Times, January 6, 1986, regarding this issue. They discuss in detail the commitment to the family and the involvement of one's time.

To help correct this concern, I ask the Select Committee on Aging to work closely with community agencies in developing foster care programs for the elderly and with nursing homes such as St. Camillus, in the further implementation of day care programs for the elderly.

HMO's, this is on the per capita base, the HMO would provide the support services. I think we may hear more about this in the future.

Before leaving you, I must also express my concern regarding the proposed Medicare regulations on reimbursement for home care. It is my understanding that this will be more restrictive and limited to the recipients of the Medicare Program. If these proposed reimbursement guidelines are implemented, it will be counterproductive to a longstanding Federal and State goal of obtaining more alternative care programs instead of nursing home placement.

Thank you for the opportunity to present this paper.

Mr. WORTLEY. I appreciate very much your contribution today and we will back with some questions in a few moments.

[The material submitted by Mr. Conole follows:]

[From the New York Times, Jan. 6, 1986]

MANY IN WORK FORCE CARE FOR ELDERLY KIN

(By Glenn Collins)

New research on the family responsibilities of workers shows that an unexpectedly high percentage of full-time office employees spend significant amounts of time caring for eldely relatives and friends.

The study, believed to be the first comprehensive look at full-time employees at a large corporation who spend time caring for the elderly, offers new insights into the stresses involved in juggling such duties while still fulfilling work and household responsibilities.

The research focused on 739 of 10,000 employees at the Travelers Corporation in Hartford, the insurance and financial-services company with $40.9 billion in assets. Following are some of the findings:

Twenty-eight percent of the employees studied, all over the age of 30, said they spent an average of 10.2 hours a week caring for elderly relatives and friends 55 years old and over. Eight percent devoted 35 hours a week to such care, the equivalent of an average work-week. Some full-time employees spent as much as 80 hours a week.

Eighty percent of those studied said that caring for the elderly had interfered with other family responsibilities and with their social and emotional needs. Thirty percent had not had a vacataion from care-giving duties for more than a year.

Care-givers had been providing aid for an average of 5.5 years. Forty-two percent of them had daily contact with their elderly relatives and another 35 percent had contact several times a week.

The care-givers were predominantly women. Only 29 percent of men in the study said they were the primaray provider of care for an elderly person. Many men relied more heavily on their spouses and on outside assistance than did the women.

Forty-six percent of those cared for were mothers, 19 percent fathers, 9 percent were friends and the rest were other relatives.

The average age of those receiving care was 77.2 years and 69 percent of them were women. The majority of those receiving care, 62 percent, were living relatively independently in their own homes or apartments.

"I was surprised that the percentage of people providing care was so high and surprised at the sheer amount of hours spent in care-giving," said Dr. Glenn T. Ball, director of personnel research at the Travelers Corporation. He conducted the study

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with a colleague, Barbara Greenberg, an administrator with a master's degree in social work who supervises the company's national and community-affairs programs.

Dr. Ball said that since the study focused only on the corporation's employees, the findings could not be said to be representative of the general population. However, the results were consistent with those of previous studies demonstrating the central role of families in caring for the elderly. For example, research in the 1970's by Dr. Ethel Shanas, professor emeritus of sociology at the University of Illinois, has indicated that 83 percent of the women age 80 and older live with their children, or within 10 minutes from them; for men over 80, the figure was 66 percent.

RELATIVE YOUTH OF MANY CARE-GIVERS

In the Travelers research, an unexpected finding was the relative youth of many care-givers. "We didn't expect that there would be such a high number of people between age 30 and 40 caring for older relatives," Mrs. Greenberg said. The study found that 31 percent of care-givers were in the 30-to-40 age group.

"The fact that so many employees are helping their elderly family members and friends is a very positive finding," said Harold E. Johnson, senior vice president of personnel and administration at Travelers. "At the same time, it shows that these employees may have need for information or support. Community service organizations and other corporations may not be aware that this is such a large issue and we hope to get them thinking more about it."

The research, which was conducted during the previous six months, was based on a random sample of 1,412 of the 7,000 workers over the age of 30 working in the company's Hartford office. Ultimately, 52 percent of these employees participated, 43 percent of whom were men and 57 percent women. All were promised anonymity.

Those studied came from all employment levels, ranging from senior managment personnel to those working in the mailroom. "We wanted to know if there were significant numbers of employees giving care," Mrs. Greenberg said, "What kind of care it was, what problems it might be causing and whether there was anything that Travelers could do to help."

The research was designed with the assistance of Connecticut Community Care Inc., a nonprofit, statewide organization that gives advice on managing care for the elderly.

The study found that 52 percent of those giving care were adults between the ages of 41 and 55, manly of whom were attempting to satisfy the needs not only for elderly parents but also those of their own children.

In the most severe cases, "people were physically and emotionally exhausted from the time and activity involved," Mrs. Greenberg said.

Dr. Ball added that it was possible in some cases that the stress of caretaking was affecting workers' productivity or causing absences, but that employees studied had not been asked about this directly. "We had to make sure that our questions didn't make employees "feel threatened in any way," he said "We didn't want to make people worry that we'd find out they were under a great deal of stress and might need to take off work time to solve some of their problems."

Those giving care provided a variety of services to the elderly, most frequently offering companionship and transportation. More than half of those studied also performed household tasks such as cooking, cleaning and laundering, and 44 percent managed the elderly person's finances. Thirty percent provided direct financial support.

AMONG THE AILMENTS

Only 3 percent of the elderly being cared for had no medical problems; 51 percent had two or more ailments. Vision and hearing impairments, swollen legs, arthritis, depression and high blood pressure were among the most common and were experienced by at least a third of those receiving care.

When asked, 80 percent of the care-givers felt that information about community resources would be helpful. Sixty-seven percent were interested in more information on home care and 64 percent about choosing a nursing home.

Mr. Johnson said the Travelers company was considering ways to make such information available to employees. "We'd like to provide them with good, solid sources of information available in the community," he said. "We're looking at the possibility of inviting in speakers, of having lunch-hour meetings about care-giving, of getting together support groups and seminars, and of putting together some educational videotapes."

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Mr. Johnson said he believed that such activities were in the interest of Travelers. "If our people don't spend as much time worrying about those at-home issues, we'll get more productivity and loyalty," he said. "And the companies that don't do the things we're doing in this area won't have such quality work force."

Mr. WORTLEY. Dr. Davin.

STATEMENT OF DAVID DAVIN, M.D., PRIMARY CARE PHYSICIAN, SYRACUSE, NY

Dr. DAVIN. Let me introduce myself as a primary care physician and subspecialist in pulmonary medicine, and I am also trained in cardiology and deal with a large number of desperately ill people both in the hospital and as outpatients.

Several months ago on a Saturday morning and in response to a letter from Congressman Wortley, he and I spoke at length at his local office about cost containment in medicine in the 1980's. At that time I identified to the Congressman three focal points which I believe to be of critical importance in this matter. What I would like to do today is present these issues, relating them ultimately to home care for our senior citizens.

I think that most discussions of cost containment that one hears or reads in the media or even coming from Washington are embarrassingly shortsighted. Nowhere in these discussions does one hear the issue of prevention of disease and disability discussed as a means of containing health care costs. Rather, what we hear is a discussion of the enormous amount of dollars spent on health care and suggestions to limit the dollars spent by limiting what the providers and distributors of health care can charge. Certainly these are important considerations, but far more important in my judgment is the discussion of the role of the individual in the maintenance of his own health and the ultimate limitation of the health care costs that he and therefore society will accrue. One need only look at the health care cost as well as the general economic cost of cigarette-induced diseases to see that so much of what we spend in health care today is thoroughly preventable; and yet no one discusses this aspect of cost containment. One need only walk up and down any street or attend any public gathering to see the enormous number of smoking or obese or severely deconditioned people that draw an enormous and disproportionate burden of health care dollars. Yet, as of this date, nonsmokers and people who maintain an ideal body weight or pursue regular physical exercise are forced to pay the same health insurance premiums as those of us who pursue wholly and healthy life styles.

I quote now from the New York Times, September 16, 1985: "A Federal agency has estimated that $12 billion to $35 billion will be spent in the United States this year to treat smoking-related diseases." This agency, the Office of Technology Assessment, also estimated that smoking-related diseases would result in productivity losses to the economy of between $27 and $61 billion. The office, an arm of the Congress, made the study at the request of Representative Fortney Stark, Democrat of California. Mr. Stark is chairman of the Health Subcommittee of the Ways and Means Committee.

The study goes on to indicate that the Federal cigarette tax yields only $4.6 billion per year, and once again I remind you that the costs generated by cigarette induced diseases is $12 to $35 bil-

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lion per year. The study based its findings on a review of several previous studies, especially those of the American Cancer Society.

This agency's latest estimate is that 139,000 people died in 1982 from smoking-related cancers. Deaths from cardiovascular diseases associated with smoking were estimated at 123,000, and deaths from noncancerous chronic lung diseases linked to smoking were put at 52,000.

The study further addresses the contribution of Medicare to the overall health care costs caused by smoking. Representative Stark had asked the Office to estimate the health care costs linked to smoking that are paid by Medicare.

The agency put that cost at $1.7 to $5.4 billion per year. Medicaid footed a total of $300 million to $1.1 billion per year and this study, even though it associated smoking to deaths attributed to digestive system diseases, accidental fires, miscarriages, stillbirths, and early deaths of infants whose mothers smoked, did not figure in the cost of those diseases in figuring these final estimates.

Certainly the concepts of prevention have been extended to automobile care as well as care of our dwellings but for some reason the concept of prevention as a means of containing costs in medicine has lagged far, far behind. Could it be that the public's expectation of what medicine can do vis-a-vis the provision of artificial and bionic organs and other technology has allowed the public to believe that a chronically poisoned human body can at any point be restored to normalcy at bargain basement prices? Certainly efforts should emanate from more than just the medical community to encourage our public to pursue a healthier life style and to eliminate such decidedly unhealthy and extremely costly such as the use of cigarettes, overuse of alcohol especially while driving, the overuse of food and failure to use seat belts. These measures alone, I am sure, would result in enormous health care savings to all parties concerned, and let us not forget would make us all on the average considerably healthier.

A second issue in medical cost containment focuses on the payment that health care providers such as myself and hospitals must make to provide their services. As an example I offer a notice I recently received from my landlord who, by the way, is an exceptionally nice and professional fellow, stating that any rent payment not received by his office by the fifth of the month would necessitate a 10 percent finance charge. Since I already pay $1,000 a month, this would result in an additional $100 a month. I sent the letter back acknowledging this notice but asking whether or not I should pass along this finance charge to my sick, crippled, and injured patients, many of whom had barely survived long, intense stays in the hospital. I have yet to receive a response to that letter.

We must also wonder, of course, about the costs charged by the makers of the technology that we all depend on so much for diagnosis and treatment. When a health crisis occurs, when a person coughs up blood or has chest pain or passes out or fears a cancer, that person doesn't want to hear that a CAT scanner, needed to diagnose his tumor, costs $1 million or that the radiotherapy machine designed to rate that tumor costs hundreds of thousands of dollars or that the operating room or the drugs or the various tools that have made 20th century medicine so successful are extremely

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expensive for doctors and hospitals to purchase. What that person wants to know is that the best physician is immediately available at the best hospital with the best equipment at a moment's notice.

Of course after the doctor-patient and hospital-patient interaction ensures and the patient receives his bills, he then looks immediately and unfortunately only at the providers of his care as being responsible for the magnitude of those bills. The providers of medical equipment, drugs, medical buildings, et cetera, operate with a bottom-line mentality and their charge is limited only by what the marketplace will bear. Nowhere in public discussions of cost containment does anybody ask why a CAT scanner must cost a million dollars, even if the research and development for that scanner took place 10 years ago. What people ask instead is why the physicians and hospitals that have to pay these enormous prices for this technology charge what they do and of course with the advent of designated reimbursement groups by Medicare, we see once again stiff limitations not on the makers of the technology or the drugs but on those people who work long and hard to provide the care.

I would like to quote now from a Medicare bulletin issued some time ago regarding payment for cardio-pulmonary resuscitation:

> The DRG system of payment has been instituted by HCFA for cardio-pulmonary resuscitation (CPR). This is necessary due to the inappropriate number of patients undergoing CPR in the hospital, particularly in the ICU, CCU, and emergency room.
>
> For an additional three-month trial period, the hospital will be reimbursed for the first eight minutes of cardio-pulmonary resuscitation. Further resuscitative efforts will require the approval for the medicare consultant, who will then approve additional CPR time in five-minute increments.
>
> HCFA is rapidly making the necessary arrangements such that the medicare consultant can be reached on a nationwide toll-free number. It is estimated that at least ten telephone lines will be provided to expedite the handling of phone calls.
>
> CPR will be classified into CPR 1 and CPR 2 to determine the medicare payment to the institution. CPR 1 is cardio-pulmonary resuscitation without the use of intravenous calcium, while CPR 2 includes the use of up to but not over three ampules of intravenous 10 percent calcium.
>
> CPR 2 will require prior authorization from the medicare consultant or payment may be denied. If the use of intravenous calcium is anticipated, it is strongly advised that a phone call be placed at that time to the medicare consultant.

This was sent to me as a member of my hospital's acute care committee and the chairman of that committee said the attached would be funny if it weren't so serious. He is correct.

A third and equally poignant issue in Medicare care costs centers around the malpractice issue and nowhere is this more intense than New York State. Several weeks ago I had occasion to meet an extremely bright, well-trained young physician contemplating leaving Stanford University to enter practice. She asked me my opinion about practicing in New York State where she had some family, and I am afraid I had to advise her to find some other State altogether. One cannot deny that negligent physicians unfortunately practice medicine in this and every State. But this should not allow us to lose sight of vast number of doctor-patient interactions that occur every day and are wholly within the confines of quality medical standards. It is unfortunate that compassionate, well-trained, excellent physicians must practice medicine with the gun of a plaintiff's attorney at their head.

What this has meant is that every patient, like it or not, must now be regarded by his or her physician as a plaintiff in a lawsuit

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until proven otherwise. This, of course, has resulted in an enormous expenditure as consultations, tests, and other modalities that would otherwise not be employed are in fact employed simply to provide an adequate defense should anything less than a perfect outcome arise and the physician in charge find himself in court fighting for the future of himself and his family.

I cannot purchase more than $1 million of malpractice. By recent State law, my hospital can provide a second million dollars of coverage, but unfortunately there are many, many jury awards that exceed this value. Such a decision, if it exceeded a million against me, would completely devastate my professional career as well as the future of my family. This, to me, is not an acceptable mode of operation. There is indeed a liability crisis that extends far beyond medical care involving all services from skating rinks to ski resorts to municipalities to drug manufacturers. Unfortunately, there are far too many plaintiffs attorneys who would be willing to devastate a physician's future or that of any other physician to garner the one-third of the award they seek to gain. Surely we can do something about negligent physicians without penalizing all of the competent physicians that currently practice and at the same time inflating the cost of hospital bills by as much as 25 to 40 percent according to some estimates.

The malpractice situation, especially in the State of New York, will ultimately result in high quality, industrious physicians either not coming to the State or leaving the State or pursuing other options that remove them from what was once the thrill and excitement and compassion of clinical medicine. I do not believe that our aging population should have available people who entered medicine only because they could pursue no other field of endeavor. Rather, I would like to think that the public would like its physicians to be well trained, skillful professionals that enter medicine willingly even though they could do other things perhaps far more lucratively.

In summary, then, it is these three issues that I would like to bring to public awareness in an effort to control medical costs: First, the necessity of the prevention of disease and the profound ability of the public and every individual to lead a healthy life style and limit in a major way the health care costs that attend the alternative of self-destructive behaviors.

Second, we must, I believe, restrict what the providers of technology, drugs and other medical tools can charge to health care professionals and hospitals if we in fact are limiting what those providers of services can charge.

Third, we must immediately develop significant, meaningful reform in jury awards and the tort process in medical malpractice cases. I am confident that if these measures are undertaken, we will see a decline in the cost of medical care in this country. If they are not undertaken, we will see a further expansion in what are already enormously large costs and a decline in the quality of medical care that we have all come to expect in this country.

Thank you.

Mr. WORTLEY. Thank you, Doctor.

[The material submitted by Dr. Davin follows:]

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[From the New York Times, Sept. 16, 1985]

SMOKERS' ILLS COST BILLIONS, U.S. SAYS

(By Irvin Molotsky)

WASHINGTON, September 15.—A Federal agency has estimated that $12 billion to $35 billion will be spent in the United States this year to treat smoking-related diseases.

The agency, the Office of Technology Assessment, estimated that smoking-related disease would also result in productivity losses to the economy this year of $27 billion to $61 billion.

The office, an arm of Congress, made the study at the request of Representative Fortney H. (Pete) Stark, Democrat of California, who plans to release it Monday. Mr. Stark is chairman of the Health Subcommittee of the Ways and Means Committee.

Mr. Stark and others in Congress are trying to assess the health costs attributable to smoking, mainly of cigarettes. The assessment is likely to be used in Congressional debate over the Federal cigarette tax, now at 16 cents a pack, but due to revert to 8 cents a pack at the end of this month unless Congress renews it.

$4.6 BILLION FEDERAL TAX YIELD

The Federal cigarette tax yields about $4.6 billion a year. Many antismoking activists both in and out of Government have called for increasing the tax in an effort to discourage smoking. They have asserted that, fatalities aside, cigarettes cost the nation far more in medical costs than cigarette taxes provide.

The Office of Technology Assessment based its findings on a review of previous studies, especially those of the American Cancer Society. The agency's latest estimate is that 139,000 people died in 1982 from smoking-related cancers. Deaths from cardiovascular disease associated with smoking were estimated at 123,000, and deaths from noncancerous chronic lung diseases linked to smoking were put at 52,000.

The major data base for the report is a study of a million Americans carried out by the American Cancer Society from 1959 to 1965. Describing its statistical method, the report says: "Using the death rates for cancer, cardiovascular disease and chronic lung disease for nonsmokers who were enrolled in the study it is possible to calculate the expected number of deaths that would occur if no one in the U.S. smoked. Subtracting that expected number from the number that actually occurred yields an estimate of the deaths that may be attributed to smoking."

MEDICARE ESTIMATED

Advance copies of the report, "Smoking-Related Deaths and Financial Costs," were made available by antismoking activists over the weekend, when spokesmen for the tobacco industry were not readily available for a response. The Tobacco Institute which represents the cigarette industry, has long taken the position that smoking has not been scientifically linked to illnesses and deaths.

Representative Stark had asked the Office of Technology Assessment to estimate the health-care costs linked to smoking that are paid by Medicare, the Federal program that provides health care to people over 65 years old. The agency put that cost at $1.7 billion to $5.4 billion a year.

The Federal share of such costs paid by Medicaid, the state-administered program of health care for the poor, was put at $300 million to $1.1 billion a year.

The death figures were stated as the middle estimates of the ranges contained in the studies analyzed for the report. The total of smoking-related deaths caused by cancer, cardiovascular disease and noncancerous chronic lung disease was estimated in the technology office's report at 314,000, but the range in the studies analyzed was 186,000 to 398,000.

This range, the report said indicates "some uncertainty about the exact magnitude of the smoking toll."

COMPLICATING FACTORS CITED

Some of the studies that were analyzed linked smoking to deaths attributed to digestive system disease, accidental fires or miscarriages, stillbirths and early deaths of infants whose mothers smoked while pregnant, but these are excluded from the Office of Technology Assessment's estimates.

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The estimate of productivity losses was based mostly on wages lost because of smoking-related illness and what the study called "future earnings lost due to premature death."

The technology office acknowledged that complicating factors made estimating difficult. "For example," it said, "smokers also tend to be relatively heavy drinkers of alcholic beverages. Thus, an apparent excess of disease in smokers may not be because of the use of tobacco, but due to the consumption of alcohol."

Such alcohol-related diseases as cirrhosis of the liver and ulcers among smokers were excluded from the study.

Also excluded were "nonsmokers who are exposed to cigarette smoke," who "may have an increased risk of disease compared to people not exposed to tobacco smoke."

The project director of the Office of Technology Assessment report was Karl Kronebusch. Free copies of the report may be obtained by writing to the office at 600 Pennsylvania Avenue S.E., Washington, D.C. 20003.

Mr. WORTLEY. I am certainly glad you read that bulletin from HCFA because it serves as a warning to all of us the next time we have a cardiac arrest, don't require more than 8 minutes of CPR or we are in trouble.

Dr. DAVIN. I have yet to determine what inappropriate CPR is. I was hoping someone could answer that question for me.

Mr. WORTLEY. Thank you very much. You do have to maintain your sense of humor.

Dr. Myron Miller, the platform is yours.

STATEMENT OF MYRON MILLER, M.D., ON BEHALF OF JOHN BERNARD HENRY, PRESIDENT, STATE UNIVERSITY OF NEW YORK HEALTH CENTER AT SYRACUSE

Dr. MILLER. Congressman Wortley, ladies and gentlemen, it is my pleasure to welcome you here on behalf of the upstate medical center. This afternoon I speak on behalf of John Bernard Henry, president of the State University of New York Health Center at Syracuse, and we welcome this opportunity to address the House Select Committee on Aging through these hearings.

The Health Science Center is an institution with multiple missions including the provision of education and training to a wide range of health care professionals, the conduct of research and the provision of health care to the residents of the central New York area.

You may ask why the issue of home health care services for the elderly is of concern to this institution. As a consequence of recent and proposed changes in Federal budgetary policy, a number of sweeping social changes are imminent, which are likely to affect health care of the elderly, both directly and by altering the ability of health care institutions to carry out their functions. These changes have the potential to involve housing, transportation, nutrition programs and home care services, all of which interact with the service delivery programs of this Health Science Center. Thus, they are properly of concern to an institution such as ours.

The Health Science Center at Syracuse provides a broad range of services, ranging from ambulatory and primary care to tertiary, inpatient care. These services are delivered to a diverse population which encompasses all levels of the socioeconomic scale in both the immediate geographic area and in a wide referral area extending from Canada to Pennsylvania and from Auburn to Utica.

In general, the patients treated at our center are sicker, have multiple or more complex problems, and are older than those cared

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for in other health care facilities. As a referral center, the University Hospital is often the institution of last resort for these patients.

Affecting this patient population are a number of recent changes, the most drastic being the implementation of the diagnostic related group reimbursement system. Many of the patients served by this University Hospital have an average length of stay greater than that found in many community hospitals. Often this is because the patients do not have a home situation which can support the early discharge policy which is part of the DRG system.

Consequently, at the present time approximately 12 percent of the beds at University Hospital are occupied by patients whose needs might be met in an alternative care setting, including the home.

Yet, Federal and State policies limit the number of long-term care beds in the central New York area and the accessibility of these beds to patients. Equally important is a policy which affects the availability and financing of home health care as an alternative to institutional care.

Although pioneering programs have been developed in New York State which provide alternatives to institutional care and which help in alleviating the problem of inappropriate prolonged stay in acute care institutions, these programs are limited to specific segments of the population and in many cases, accessibility is limited by the financial resources available to the individual.

Even though Syracuse and Onondaga County are considered to be rich in alternative health care resources, including home care services, evidence is beginning to mount which indicates that many elderly patients who are prematurely discharged from the acute care system are unable to gain access to home services because of costs involved, with resultant adverse effects on their health status which ultimately lead to readmission into the hospital.

When one considers the paucity of resource existant in the rural areas which make up the bulk of the 15 county central New York community which we serve, then the magnitude of need and problem becomes evident.

Making the home health care system affordable, then, is of increasing importance. It is necessary to allow for the efficient and appropriate use of expensive inpatient hospital resources; it is necessary to allow for continuity of care initiated in the hospital setting; it is necessary to minimize the likelihood of rehospitalization resulting from early hospital discharge; it is necessary to prevent premature placement into long-term care institutions; and finally, it is necessary to allow our elderly population the capacity to live and participate in the community which provides meaning and value to their existence.

Therefore, policy which limits or excludes large segments of the elderly population from home health services must be changed. Recognition must also be given to the fact that a broad range of home services must be made available so that the type which is most beneficial as well as most cost effective can be provided, with choices made on the basis of need rather than on statutory eligibility.

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This institution plans to participate in the movement to provide improved home health care services by addressing in an interdisciplinary fashion the educational needs of a broad range of service providers, including physicians, nurses and allied health professionals, and by incorporating this aspect of the health care delivery system into the spectrum of services provided by the Health Science Center.

Thus, this center will expand its role in the rapidly changing health care delivery system by serving as advocate for the needs of the elderly population and by examining its own programs so that the missions of education, research and service delivery reflect the needs of the population.

Thank you for this opportunity to share our concerns with you. We hope that the hearing will contribute to the capacity of the House Select Committee on the Aging to develop policy which will improve our health care system in a compassionate yet fiscally responsible manner.

Mr. WORTLEY. Thank you, Dr. Miller.

The observations of all of our panelists are very well taken. I wonder if I might pose this question and start with our two physicians.

You gentlemen believe the elderly are being discharged from hospitals prematurely and is that an assumption based upon their condition at the time of discharge or is that predicated upon the environment that they will have to enter into if there is subsequent recovery?

Dr. Miller.

Dr. MILLER. We have been beginning to develop data now primarily at the Veterans Hospital, which I should remind individuals, is subject to the same kind of DRG system only under a different name than that which is operative in the community. The annual budget for the VA is predicated on rapid turnover and the hospital is penalized for prolonged term of stay contrary to misconceptions.

We are now keeping records of readmission back into the hospital of patients discharged from the hospital system and finding a rapidly increasing percentage of individuals readmitted within one and two weeks of discharge.

In reviewing the records of the individuals and reviewing reasons for discharge, in virtually all of the cases discharge was hastened by the necessity to comply with the length of stay requirements which had been established for the diagnosis which these individuals carried. We expect that this will continue to become a greater and greater burden as the capacity to comply with the DRG type requirement actually improves.

We are relatively unskilled at this yet. In fact, we get chastised by our administration for not following as well as we should the guidelines for discharge. I do not have as yet data from the University Hospital reflecting the readmission rate but I suspect that the same situation is true.

I have spoken to a number of individuals who work predominantly in the admitting areas in hospital emergency rooms and their statements, not quantified, but their statements are that they are

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now seeing the same patients over and over again, a revolving door effect.

Dr. DAVIN. There was a time when Dr. Miller and myself could discharge a patient from the hospital based solely on our assessment of his medical condition, how he had responded to our treatment intervention and the ability of his family or whatever social organization as it existed to take that individual home.

Unfortunately, what has happened is that now one finds disturbing notices, a physician finds disturbing notices in his mailbox indicating that such a patient spent 7 or 10 extra days in the hospital and that this resulted in a cost to the hospital of x number of dollars and that as this patient's physician, you may be held personally responsible for this bill, this excess, should it happen again.

I have not gotten a letter like that, fortunately, but many of my colleagues at a certain hospital in town have and what that means is that once again it is a different gun at the head of the physician. He is damned if he does and he is damned if he doesn't.

If he discharges the patient in keeping with the DRG guidelines, the hospital is happy because they don't lose money from providing care and services to the patients. On the other hand, if the patient goes out and has a relapse and ends up being readmitted, he is often followed to the hospital by a plaintiffs attorney asking if the patient wishes to sue the hospital or physicians that discharged him. You cannot win in this type of environment and many physicians share that sort of frustration.

I brought the CPR example because it is ludicrous and yet those principles apply to all forms of patient care, and it is just an inadequate way to take care of sick people.

Mr. WORTLEY. I am told in central New York, particularly, we have an excellent professional review process. Perhaps much of it is attributable to the fact of the good quality of institutions we have as well as having the medical center here.

What has been the experience of patients who are, shall we say, sent home? Are we pushing them out much faster because of the DRG, faster than we might have put them out previously?

Dr. DAVIN. Absolutely.

Dr. MILLER. There is a second dimension to that too. Not only is the underlying problem for which the individual—the underlying which brought the individual to the hospital being addressed in a more rapid fashion but particularly in the situation of our elderly patients who often have coexistent processes often which are not recognized or have been inadequately treated in the past. When these problems are identified, one does not have the opportunity to fully delve into the nature of the problems and provide the appropriate form of treatment.

Treatment is predicated on the basis of the diagnosis which brought the individual to the hospital regardless of what else may be present and you cannot in that hospitalization provide for other problems which are turned up.

Mr. WORTLEY. Mr. Conole, you wanted to comment.

Mr. CONOLE. Let me take the risk of being the devil's advocate here. Diagnostic related groups, this is the first year for New York State so there is also a period of adjustment. Other States have had

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prior experience, some up to 2 years. Because really this hasn't been done in a vacuum.

There has been extensive research done on diagnostic related groups for the past 10 years. This originated from a study at Yale University under Dr. Thompson and he worked extensively with the Federal Government and the State of New Jersey for the 468 groups, so the system wasn't done in a total vacuum.

At the same time I will state that this is for all hospitals across the country, so for tertiary centers like State University Hospital and Crouse Irving Memorial, State Hospital, over 50 percent of their admissions are from outside the country, so you are dealing with a little different intensity.

I foresee the DRG's there will be adjustments and hopefully they will be adjustments to address the tertiary care system where there is the multiple diagnosis. At the same time, I think the issue of discharge planning keeps cropping up in the literature. This is a team approach and it is to everyone's benefit to get the patient back into the home setting as soon as possible.

So I think DRG's can be of tremendous assistance to the acute care system by helping to move the patient back into the home setting as soon as possible. Within New York State and the DRG system, we are going to have to reassess this. It is too early to tell on readmissions. We have quality assurance committees.

I would hope this would be a priority of addressing this issue within the next year at quality assurance committees on any readmissions on a departmental basis, the readmissions into the emergency room on a 48- or 72-hour basis or readmissions for the same diagnosis within a 2-week period.

I think once we have the assessments, it would be wise to get back to you.

Mr. WORTLEY. The statistics have not yet come in?

Mr. CONOLE. From my perspective, they haven't.

Dr. MILLER. The system has been in operation 6 weeks, but in the VA it has been in operation for over a year now. We are finding that about 30 percent of our admissions are readmissions of individuals who have been discharged within a period of 2 weeks.

Mr. WORTLEY. It was a former central New Yorker who was the originator or launched the DRG program, Dr. Carolyn Davis, who was in Syracuse for many years before she went to the midwest and came back to Washington as the first administrator of HCFA in the Reagan administration under Secretary Schweiker.

Mrs. Wurzburger, you talked about HCFA's restrictive edicts on Medicare payments for home care. If you were to offer one suggestion, one proposal, a single wish, shall we say, on this St. Valentine's Day, what might it be?

Mrs. WURZBURGER. Well, there are quite a few edicts, OK?

I did mention the one that has not come into being yet, and that is the one on the copayments. I really feel very strongly about this, that the elderly person has a lot of difficulty sometimes understanding what the effects of copayments are, and how to handle them, and I really feel that this will be a discouragement to them to seek medical care, health care if they need it.

I am talking about the patient, just for an example, who has a stroke and is not hospitalized. This is happening more frequently

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now. The patient will have a stroke at home, a physician will call and see the patient at home and will not hospitalize the patient, and these are the types of patients that will fall into that area of the copayments. And I feel that we need to get that patient into the system of health care because they can't be rehabilitated, rather than continuing on a downward decline.

Mr. WORTLEY. Good point.

A few moments ago there was a mention of the social HMO. I think Mr. Conole mentioned that, but I am wondering if Mr. Cardillo has had any experience in Albany. Has that surfaced at the State level yet?

Mr. CARDILLO. There is a social HMO called SHMO in Brooklyn. I am not aware of their initial experiences with the program. It really hasn't been in operation for a long period of time.

The idea, though, is to try to provide a comprehensive range of needed care to an elderly person on the pre-paid capitated model but I am not aware of their specific experiences with the program yet. But New York has a program in Brooklyn.

Mr. WORTLEY. I will make a deal with you. You talk about catastrophic health insurance and next time we have this committee meet, with more members present, it will be holding a hearing on catastrophic health insurance.

I will get you transcripts of that meeting if you will get transcripts of the social HMO.

Dr. DAVIN. As long as the attending physicians of patients who could be treated at home are faced with the possibility of litigation by sending the patients home those physicians will opt to keep the patient in the hospital, to admit him to the hospital or in some way make sure that should they come to a courtroom situation they are protected and I think it is important for everybody in this room to understand that defensive legal medicine as it is being practiced right now contradicts every goal of this committee on cost containment in providing home care and myself as a physician that has discharged many, many patients from the hospital, given the option of litigation and being exposed or libel in any way I would choose to keep that patient in the hospital and bill the system, as it were, rather than make myself libel for an award a year later which could amount to millions of dollars which I don't have.

Mr. WORTLEY. Your concern for the legal aspects is greater than incurring the wrath of the hospital administration who puts a note in your box?

Dr. DAVIN. I have never gotten such a note in my box.

Mr. WORTLEY. Before we let this panel move off and the next panel come aboard, I have a couple of minutes up there, I wonder if there is anybody in the audience today with a quick observation related to this panel or a very quick question that would like to address.

Mrs. COBURN. I am Norma Coburn. I would like to ask if it is not a rule somewhere that a patient can demand a 24-hour review before being dumped out—can't they legally do that?

Dr. DAVIN. I am not aware of such a rule. I have never dumped a patient out. I would hope that would be the case. Mr. Conole can speak more knowledgably.

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Mr. CONOLE. I am not aware of any rule, but I would hope with good discharge planning that we would not be confronted with the term "dumps".

Mrs. COBURN. That is my expression.

Mr. CONOLE. Again, Medicare, the medical and State guidelines are increasing day-by-day and one could almost have a full time job between reviewing the current guidelines in the current health care literature if you wanted to.

Mrs. COBURN. I sent to AARP for a brochure called "Patients' Rights", and they urged everyone to study this before they entered the hospital and it seems to me I read somewhere that there is a point where a patient has a certain number of hours that their case must be reviewed before they are discharged if they are unhappy about it.

Mr. CONOLE. Let me state a point. The State Health Department under the surveying process, section 405 of the State Health Code, does require a patient bill of rights, each hospital to have, and I believe those guidelines would be addressed, but maybe not in the specificity that Dr. Miller can.

Dr. MILLER. There is a formal review process, but the problem is it is very difficult to get access to it. The hospital administration is unaware of the mechanism and you can be sure that the providers at the bedside level are completely unaware.

Mr. WORTLEY. My question would be does the patient bill of rights also extend to CPR?

Dr. DAVIN. Your question is extremely well taken but there is another dimension. The whole situation takes the patient, the physician and the hospital administrator and makes them antagonists.

Mrs. BILLFORD. I am Roz Billford, Metropolitan Commission on Aging. I think we realize that home care impacts tremendously on the elderly. Many speakers have pointed out that certified home health agencies, population is generally 75 to 80 percent of the elderly.

I stress the need not only for the certified programs already being done, but the need to expand respite programs. We know we as an organization were instrumental in setting up a central New York Alzheimers chapter. We know there are many people being taken care of at home that belong in an institution that we must provide things like respite and other kinds of supportive home health services if they are to maintain their independence.

I got my allocations today under the Older Americans Act and based on Gramm-Rudman, this agency got a 4.3-percent cut today which translates to a 5-percent cut because of the population statistics in New York State. While we may talk about home care, the need to keep people at the lowest level of care, I would hope that as we review the cuts we would recognize the difficulty of taking them across-the-board.

I am sitting here today trying to determine how we are going to save some programs that are supportive programs in home care that will enable old people to remain at home. I think we have got to keep these in mind recognizing that that population in our society, 75 and 85, are the most increasing in numbers and the most increasing in the need for home care.

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Mr. WORTLEY. Referring to your concern on Alzheimers, Chairman Roybal of this committee is introducing legislation, of which I am a co-sponsor, that would permit greater use of medicare funds. No further appropriation of funds, but greater use of medicare funds in the treatment of Alzheimers, and I think we will have a considerable amount of support on that and it certainly is a step in the right direction. That doesn't resolve your problem on the 5-percent cuts.

I think we must change panels at this time, so if you will bear with us, ladies and gentlemen, in the audience, I wish to thank these panelists for your great contribution. All your remarks are on the record and will be carefully analyzed and I am sure will ultimately result in some legislation or certainly changes of regulations in the improvement of home health care.

Thank you very much for your contributions today.

Mr. WORTLEY. Our next panel is comprised of four central New Yorkers which include this afternoon Agatha Slater of the Madison County Public Health Nursing Service, whom I might say I spent an enjoyable lunch with the other day visiting with members of her staff and I was enlightened considerably about problems of home health care during that session, so this becomes a further extension of our meeting. Thank you, Agatha, for appearing this afternoon.

Also, Girdon Buck, the president of VIP Companion Services. Girdon and I have spent considerable hours together talking about the services that your organization and comparable ones to yours render to our community.

Ann Heimer comes with the expertise of the Visiting Nurses Association, and we are so happy that you can join us today. And certainly last, but not least, is John Farnham, a local attorney who is going to speak from a different vantage point than anyone else has spoken, namely, that of a family who has opted for home health care and also uses the VIP Companion Service.

Let's start with Mrs. Slater.

STATEMENT OF AGATHA SLATER, MADISON COUNTY PUBLIC HEALTH NURSING SERVICE

Mrs. SLATER. Thank you very much.

I am happy to be here and to continue our discussion of home health care. The home health care agency that I work with is Madison County Public Health Nursing Service, and it is at present the only certified home care agency in Madison County—which has a population of about 65,000 persons. Approximately, 10.1 percent of that population are over 65 years of age and I would say that 80 percent of our referrals, the patients that we provide care to through our agency, are in that over-65 age group with a very large proportion of them being in their late seventies, eighties and nineties.

Our agency is prepared to provide skilled nursing, physical therapy, occupational therapy, speech therapy, and home health aid homemaker services. Most often, in fact, in 80 percent of the time the referrals that we receive, the client's source of insurance payment to our agency is Medicare.

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I am sure since most of us are providers and certainly have interested consumers we are aware of the medicare guidelines but just in case there are a few that aren't, I would reiterate some of them. Under Medicare guidelines our agency can provide services if:

One, the patient is homebound, that is, confined to home due to inability to leave without considerable effort. If the patient leaves home, the absence must be infrequent and of short duration, that is, doctor's visit. If a patient leaves home in spite of his restrictions for personal reasons, he would not be considered homebound.

Two, the doctor has signed orders for home care, states the patient is homebound and needs skilled nursing, physical therapy or speech therapy on an intermittent basis. If the client needs 24 hours of service, that would not be intermittent and would render him ineligible for home health care benefits. If any skilled service is required, then the services of a home health aide to do personal care is also covered.

Medicare will not cover any care that is of a chronic and/or custodial nature. Therefore, when skilled services are no longer needed, aftercare is determined no longer skilled, the home health aid services also must be stopped at that point. At least will not be reimbursed for under Medicare guidelines.

Often we find after 4 to 8 to 10 weeks, our elderly clients will at least know how to take their medications properly, their incisions will be healed or they will no longer require a dressing. Their lungs may be cleared considerably. Unfortunately, they are still very weak, fragile, often living alone or with an elderly spouse and really require the services of a home health aid to assist them with personal care, getting groceries or preparing a meal. Often their return to relative wellness is complicated by ongoing chronic conditions, that is, osteoarthritis, chronic obstructive pulmonary disease.

When Medicare no longer covers aide services, if the client is on Medicaid, we can provide home health aide/homemakers to assist them in their rehabilitation, if needed. If the elderly person does not have Medicaid and 80 percent of them do not, we then offer services on a sliding scale fee depending on income. Many times patients refuse, even a minimal charge as they do not want to use up their small savings. Our agency in this past year is providing more and more free care, as we feel an obligation to look after our elderly patients.

I, and certainly the staff, see a real need for governmental policy to consider the needs of the chronically ill elderly and to allow Medicare reimbursement for needed personal care. By providing often a small amount of personal care services, overseen by the nurse, we could prevent many elderly from premature institutionalization.

We often also find, when we are doing a fact sheet to determine what the source of reimbursement is to the agency, that many patients have taken out and are paying for extra private insurance policies which they believe will help augment their Medicare home care benefits. Time after time we find that the private insurance the elderly are paying for out of their small incomes will not cover any home care services beyond that which Medicare covers. In fact, some insurers are stating that unless the client would be forced to

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remain in the hospital without the "level of care" we provide, payment to our agency will be denied.

As a graduate student, I had an opportunity to work with the Victorian Home Care in Ontario, Canada. I was most impressed with the scope of their Chronic Care Program. There, persons requiring a minimum of three visits per month of one of the professional services, such as nursing, physical therapy, occupational therapy, could receive ongoing homemaking services. If the client required person care, the nursing visit was then covered as the nurse there does the personal care rather than the home health aide. The goal of the program there was to maintain the client at their present level of functioning. Service provision was not income based.

In conclusion, I must express my concerns for a health care system that is attempting to decrease hospital length of stay for the elderly, while at the same time making home care coverage guidelines more restrictive.

Thank you.

Mr. WORTLEY. Thank you very much, Mrs. Slater.

We will, go next to Girdon Buck, who will tell us the role of V.I.P. in health care in the home.

STATEMENT OF GIRDON BUCK, PRESIDENT, V.I.P. COMPANION SERVICES

Mr. BUCK. Hon. Congressman Wortley, friends, and colleagues I bring you some exciting news from a new frontier in health care. It is preventative home care. We have all had to stay at home and care for a sick child or an ailing spouse. Life seems to stop abruptly, as we cancel appointments, postpone engagements, and take leave of work. But then in a day or two, if we are fortunate, the illness passes, and life resumes.

For many families, the illness does not pass; life does not return to normal. Day after day, they find themselves caring for a frail elderly person who shouldn't be left alone. Families living a distance from an elderly parent, like myself, find it especially difficult and are always concerned about their parent's safety.

V.I.P. Companion-Care is a professional personal service providing care and companionship to the elderly right in their own homes. Companion-Care is the perfect adjunct service for the elderly person who is beginning to have trouble coping with independent living at home.

V.I.P. Companion-Care was conceived, planned, and developed as a response to a need that is developing for my own mother, and within my own family. The policies and principles of this service are based on my several years of experience in the human services field as a counseling psychologist.

The service which began over 2 years ago in Skaneateles, is now growing rapidly in the Syracuse area, and has served well over 150 clients. We provide two levels of client service: Live in companions who provide 24-hour, round-the-clock, 7-day-a-week care, and companion sitters who provide short-term hourly daytime service as needed. The family is being serviced as well by having peace of

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mind and knowing that their very important person is being watched and cared for.

V.I.P. Care has very different service goals from other home health agencies. Our primary goal is the development of close supportive personal relationships, which dissipate the fear and loneliness of the elderly client.

We intentionally and specifically recruit for sensitive and caring individuals. We then make detailed service plans with the provider or family which will include individualized leisure and activity plans. We go to great lengths to assure the compatibility of companions and their clients through interviews and on-site evaluations, and followups.

In our terms, we seek to make a marriage. My grandfather repeatedly told me that you could never keep two women living in the same house—well, although we go against the grain, we are doing it. V.I.P. is able to manage these marriages, if you will, by forming open, genuine, and trusting relationships with our employees and clients right from the start.

We are then able to transfer the essence of their trust and sensitivity to the clients via introductions, discreet support and professional supervision. We feel that the personal care provided, although necessary and essential to continued health, is a side benefit. Our providers would agree.

Personal care includes assistance with any of the activities of daily living: Dressing, walking, grooming, toileting, meal preparation, light housekeeping, and monitoring of medical regimens. We also encourage and assist the clients to continue everyday pursuits such as reading, games, letter writing, crafts, and seasonal activities.

During the past 2 years, I have done a fairly extensive formal study on the needs of the frail elderly. Through our companion service, I am also in contact with well over 100 clients and/or their families every month. These families are seeking a wide variety of services heretofore unavailable on a professional basis.

I would now like to discuss the critical need, as I see it, for a national policy and system of nonmedically oriented, long-term, personal support services for the elderly to be provided in their own homes.

The Bureau of Census Data reports that in the United States, the age group 65 years plus, which currently numbers 25,000,000 or 11 percent of the population, will grow to 35,000,000 or 13.5 percent of the population by the year 2000 A.D. This represents a growth in true numbers of 40 percent.

The greatest rapid rise will be in the population 75 to 84 years by about 57 percent, and the population 85 years or the very old and over by about 91 percent, and females over 85 will increase by 100 percent.

A U.S. Department of Health study states that 5 percent of the elderly population, over 65, are receiving nursing care in an institution. A larger portion, over 12 percent of this elderly population, are moderately impaired due to chronic health conditions and have major activity and self-help limitations.

These chronically limited persons are often unable to fulfill one or more of the necessary daily living activities providing for their

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own physical needs. In addition, to maintain their self-esteem and a sense of well-being, they have psychological and social needs.

They are, however, essentially shut-in, confined to their own home, and are in need of regular daily assistance. It is our feeling that in most cases, this whole complex range of needs can be addressed by the provision of a skilled and caring companion.

The nature of chronic impairment implies a deficit, continuing over a period of time. Lack of any essential part of the fragile support system of these persons can precipitate acute illness and advanced entry into the costly medical system. Such short-term episodic responses—using the medical model—seem inappropriate, inefficient, and ineffective.

Continuous long-term supportive care in the home is necessary to maintain maximum independence and minimum disruption of lifestyles. It could also prove to be cost-effective.

According to the Congress Budget Office—1977—between 10 and 40 percent of the elderly in nursing homes could be cared for by in-home support services. A decision to place a frail elderly family member in a nursing home often relates more to the stress and disruption faced by the family, than on the care needs of the client.

Although families now provide 80 percent of the home health care or well care services of their elderly relatives, the proliferation of new family forms raises the question whether the nuclear family can continue to give this level of personal care to those who will be needing it.

Currently, no articulated, well-formulated national policy exists which attempts to meet the many needs of our frail elderly citizens in a manner commensurate with their preferred living in a noninstitutional, at-home setting. Nor does a policy exist which seeks at a national level to involve and support family and friends with respect to meeting the home health and home social needs of the frail and functionally limited elderly.

What seems needed is a national policy and strategy that would encompass and integrate the full range of services, medical, home health, personal care, and social care.

Such a system should be preventive in nature, by providing services as soon as functional impairment puts the person at risk. It should emphasize and encourage family responsibility through financial incentives or cooperative vendor payments.

It should recognize that the linchpin of services for the majority of the frail elderly is a personal support service, and the delivery of such service should emphasize long-term at-home care rather than acute and/or institutional care, and it would be available without the presence of a financial barrier.

Thank you very much.

Mr. WORTLEY. Thank you very much, Mr. Buck. We now turn to the Visiting Nurses Association.

STATEMENT OF ANN HEIMER, VISITING NURSES ASSOCIATION

Mrs. HEIMER. I had had some numbers prepared and some of them have already been mentioned but I would like to start with a few. Some of them came from the House Aging Committee Report of 1985.

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Mr. WORTLEY. You can be sure if it came from the House Aging Committee, they are accurate.

Mrs. HEIMER. The reason I am bringing them up is that sometimes when we are talking about health care and what is happening maybe we started looking at some of the numbers a little too far down the line and should have been looking long ago.

Going along with the numbers given by the speaker before me, another interesting number in that is in the 1970's, 5 percent of those people 65 years and over were in nursing homes at a cost of $10 billion, with 57 percent of this expense being paid for from public moneys. The House Aging Committee did report in 1985 that the elderly's health care costs are rising at twice the rate of their incomes. The study found that by 1990 the elderly will be spending almost 19 percent of their income for health care, this compared to 12.3 percent in 1977 and 14.6 percent in 1984. The projected income of the elderly will rise 4.6 percent during the period from 1984 to 1990 and the share of income to be used for health care by this group will rise at a projected rate of 9 percent.

So the reason I am giving you this information is to show you the impact that this has not only on the patients but has on those of us in health care that are trying to provide the service to meet their needs.

Home health agencies, specifically Visiting Nurse Associations, have been in the United States for over 100 years. Many of these agencies were started by small groups of concerned citizens interested in providing health care to the elderly and the indigent. This was true of the Visiting Nurse Association of Central New York, Inc. in Syracuse, which was founded in 1890.

The original concept of providing home health care still remains; however, most of these agencies have expanded into multiservice organizations. In addition to providing quality service, emphasis has long been put on operating in the most efficient and cost-effective way. In most cases, nursing home care is twice as expensive as home care.

In order to meet the most important needs of the patient by these agencies, nursing and home health aides are provided. In addition, physical therapy, occupational therapy, speech therapy, social work, and nutrition services are offered. Services can be provided to anyone under a physician's care.

Services provided by the voluntary, nonprofit agency are usually on an intermittent basis. This means that a patient is visited by the professional staff to provide services such as dressings, catheter changes, and special treatments. The visit usually lasts from ½ hour to 1 hour. The professional staff will usually visit five or six patients per day. The home health aide is usually in the home for a longer period of time to give personal care or assistance as needed by the patient.

Former health care finance administrator, Carolyn Davis, stated several years ago that finding an alternative to the present method of cost reimbursement was the major item on the HCFA agenda. HCFA's budget at that time was the third largest item on the Federal budget and as we are aware, this has not changed. According to Dr. Davis, at that time, home health care service fit into HCFA's

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goal of adopting the most cost beneficial approach to providing quality health care.

Since Dr. Davis' statement, issues have arisen that have had a strong impact on most home care agencies and the provided services. It will impact on those of us that are providing the service very strongly in the future. I would like to just give you generally the topics that will impact us.

One of the most—one of the ones that we are looking at right now is implementation of the cost caps that we must operate under as Medicare certified agencies. That will affect us very strongly in the future.

At the present there is a freeze on the caps until September 30, 1986. The diagnose related programs for hospitals have increased the number of more acutely ill patients being discharged earlier. These patients require more service and services which are usually provided at a higher cost.

Three, increase in recordkeeping, specifically the notorious forms 485 and 486, have decreased agency productivity by as much as one visit a day. Reducing productivity from five patients per day per staff person to four visits per day has a significant impact on cost. This increase in records time is also impacting the administrative staff as well.

Four, overall, there is a curtailment of home care benefits through excessively stringent regulations. More patients are being denied service and according to the published medicare regulations, the agency is not to intercede on the patients behalf and assist with an appeal for payment. For the elderly ill, this is an additional hardship.

The waiver of liability has been questioned frequently in the past. At present, this has been allowed to stay in the regulations. This waiver is extremely important to those agencies that provide services in good faith and depend on sound judgment to receive reimbursement.

Six, the change of intermediaries for many agencies will pose an additional hardship. Especially with the implementation of the 485 and 486, to change intermediaries before either agency really understands the interpretations and what is expected will cause additional problems. Even though the regulations are the same for everyone, the interpretation is always different.

This presentation has only addressed the needs of the elderly at home. There are many other people needing the same types of care available for the elderly. The elderly, however, make up the largest population of home care patient.

The services being provided in home care now address the need for social and health care services on a long term care basis, for chronic illnesses, for preventive illness, for treatments and technologies.

New technological developments are being implemented in home care which would enable older persons and younger persons to take advantage of new home-based arrangements.

Today insurance companies have become very interested in long term care insurance for nursing homes. I would like very much to see this type of insurance made available to pay for more home care services.

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After a patient is no longer considered skilled care under Medicare and for many private insurance companies, there is no funding source for the person needing care to be maintained in their own home.

Aide services are especially difficult to have funded even for the acutely ill patient, even though this level of care is very beneficial to the patient and other family members. Persons remaining in their own home or with family, respond better to treatment and generally live longer than those who are institutionalized.

Up until 1930, home remedies had been the dominant choice of treatment mainly for economical reasons. In the late 1930's, hospitalization insurance came into existence and people began entering the hospital for treatment because the cost could be reimbursed. Nursing homes started flourishing in the 1960's and especially in 1965, when Medicare was implemented.

Now, the pendulum is swinging back to care in the home. The high technology age has brought new meaning to home health care. Services previously only available through hospitals and clinics are now possible at home, thanks to advancements in technology.

Health Maintenance Organizations, (HMO's) will also have an impact on home care since patients will be able to select from a variety of insurances. In New York, HMO's will be providing home care through a certified agency.

Medicare has been addressed frequently in this presentation since this is one of the most often used third party payors. Services can, however, be paid for under Medicaid, Veteran's Administration and other types of private insurance. A patient can pay for service directly or if the patient's income is limited, fee scale is available.

I would like to add here that Medicare does not pay for all home care services. There are specific guidelines that must be followed. Unfortunately, many physicians as well as the patient are not familiar with these regulations and erroneously believe that all services will be paid for. Each patient must be evaluated by the home care staff person and material submitted with the billing for determination by a Medicare reviewer of payment.

In New York the long-term home health care program or nursing homes without walls has benefited many chronically ill patients. This program does tailor the services to the needs of the patient and works with the family to support the patient and keep them in the home as long as possible.

I hope I have given you an idea of what home care is currently and what some of the problems are that we are faced with in the future. Our agencies in Syracuse has all the problems listed and these are national problems.

Home health care is the oldest and newest phenomenon. Most communities still like to feel that families take care of their own. I believe they do if they can. My concern is that they know how to take the best care of their own, and we as home care agencies will be available to work with the patient, the family and the physician to assure this.

Thank you.

Mr. WORTLEY. Thank you very much, Mrs. Heimer.

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STATEMENT OF JOHN H. FARNHAM, JR., USER OF HOME HEALTH CARE AND V.I.P. COMPANION SERVICES

Mr. WORTLEY. Mr. Farnham, you have a loved one who prefers to remain in the home rather than go to an institution. Could you give us some reflections on that?

Mr. FARNHAM. My father was the lawyer and the judge.

Mr. WORTLEY. I am sorry. You are in the insurance business.

Mr. FARNHAM. Congressman Wortley, ladies and gentlemen, I have had a housekeeper at my mother's home since 6 months prior to my father's death in August 1978. My mother is 90. For the most part, Grace and Betty alternated 1 week off and 1 week on. This worked out very well for some time.

After my mother fractured a second hip, the care and workload were simply too much for Grace to handle. Betty did extra duty for a while and filled in with several ladies with staggered days and hours, which sometimes was confusing, especially to my mother.

About this time I read in the paper the ad concerning V.I.P. and since I have known Charley Wink for some time, this was the answer to my problem. Otherwise, my mother probably would have had to go to a nursing home, which I did not desire. I am the only survivor out of four children, so the decisions apply to me.

The V.I.P. ladies have been excellent. They are punctual and most attentive to my mother and her needs. If there is a problem, they will call me, but nothing like this has occurred as yet.

I am especially pleased the way someone goes to my mother's home ahead of time and assesses the situation. It gets expensive for a 90-year-old woman to live in a five-bedroom house and she is in a hospital bed downstairs in the living room, but I guess we will go on like this as long as we can. She takes no pills except a calcium pill and is pretty healthy even with her walker.

Mr. WORTLEY. You can understand when someone has lived one place for 64 years what an extremely traumatic experience it would be to have to pull up roots and go into another type facility and certainly it does behoove us, financially speaking to say nothing from the emotional standpoint if we can keep the elderly in their own home.

Before I start to ask questions I can't help but look out in the audience and see one person out there who I think is probably the most knowledgeable and certainly one of the most distinguished health care administrators in the northeast we have ever had, my dear friend Dorothy Pellins, who was the administrator of the Memorial Hospital for more years probably than she likes to remember.

There are so many of us grateful for the quality of health care that she established long before they were special standards out there and Federal and State codes that had to be strictly adhered to.

I am glad you could be with us today. Thanks for coming. You are in good company out there also. Mrs. Heimer, you cited a number of statistics in your presentation. My, you have a few extra statistics there that could perhaps inform us on what is the difference in cost between a nursing home versus home health care.

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Mrs. HEIMER. That one I don't have. Maybe Mr. Cardillo has it. At this time I don't.

Mr. WORTLEY. How about Mrs. Slater, does she have any numbers at your fingertips?

Mrs. SLATER. Well, I think that actually it is such an individual thing—that each person's needs in a home have to be assessed to determine the cost and often elderly in the home range from a level that would be considered proprietary home up to skilled service and therefore the amount of services they need is quite variable.

Mr. WORTLEY. Maybe I can turn to Linda Clifton, the administrator of Human Services in the county. Do you have any numbers on that?

Mrs. CLIFTON. Tell me again the specifics that you want.

Mr. WORTLEY. I am trying to determine what the difference is annually, per week or per month, between what it costs to stay in a nursing home or an extended care unit versus home health care.

Mrs. HEIMER. I can come back with a specific number that I think would help.

Looking at our patients that we have on our long-term home health care program, they are—they budget 73 percent of what it would cost per month for the—to be in a nursing home as opposed to the home health care program. We are providing very often a level of care in the home that is not provided in a nursing home.

We are doing IV's, we are doing patients with high palpitations, these are high technology skills. We have had patients on ventilators, on oxygen, so you would have to look at the patient and evaluate what that patient's needs are. In the cases that I am citing what we have done with each family and this is started before the people leave the hospital, the hospitals teach families and we go in the next day and continue with the teaching so that families are able to do this.

So it is very hard to equate what it would cost for a patient.

Mrs. CLIFTON. The rate—the per diem rate is nearly $100 a day for a patient, unskilled nursing. Of course, you people can give the hourly rates——

Mrs. HEIMER. For us to make a nursing visit the cost is about $33.

Mrs. CLIFTON. Per-hour rates for having each level of care from home health aides. I am way behind on the times now. It used to be around $6 and $7 and it went up to $11 for practical nurses.

Mr. FARNHAM. Eastside Manor is $35 a day, for the well elderly.

Mrs. HEIMER. I think a private duty nurse is about $12.75 per hour. If they went—if a person needed that level of care at home 8 hours a day.

Mr. WORTLEY. Mr. Cardillo is volunteering a statistic.

Mr. CARDILLO [speaking from the audience]. I wanted to comment in that when you are comparing the cost of care, say, in a nursing home where you have a per diem and the cost of care in a home it is two different circumstances. When a patient is at home their needs fluctuate from day to day, month to month, depending on the needs of the patient, because you are able to tailor the services to the patient's needs.

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In a facility the needs may fluctuate but the reimbursement is the same. In comparing the costs one looks at the long run and says, "is it cheaper to custom tailor services in the home, maximizing family and social support and the independence of the patient, versus what goes on in the facility?"

From what we have experienced in the nursing home without walls program, on the average when you add up all the services the patient gets it is about 50 percent of what it would cost to care for that patient in a facility.

We are talking about on the average for patients and on the average across the State, but in terms of a statistic that is probably closest. The other point is related to the fact that sometimes in home health care you are providing a level of care that is really beyond what might be provided to a patient in a nursing home, so instead of talking about the nursing home rate now you are talking a hospital rate or rehab facility rate, which produces a greater form of cost containment and cost savings than a simple comparison between home health care rate and a nursing home rate.

Mr. WORTLEY. Mr. Buck, you alluded a while back to the meaning for your client. What are some of the questions that you might make of a client before you attempt to match them up with a proper companion?

Mr. BUCK. Basically it starts when we interview the companion—the person coming in. We prefer the older companion. I have a 77-year-old working for me that is excellent.

Mr. WORTLEY. You interview the companion rather than the client?

Mr. BUCK. We interview the companion, recruit in the newspaper and personally, and we get referrals. They come in for an interview. At the present time, we have 4 hours of training, we have a handbook company policy and we have a special communications listening skills training for them and during that time we assess them and that is a skill of a service coordinator to see who fits where.

I started myself doing it until my wife came to my rescue. I interviewed the people, went to the home and looked at the home and made an assessment. We cut across all social guidelines. We have homes decorated 40 years old with a person who doesn't speak English and John Farnham's home. So we have the top and we have ladies willing to stay 3 or 4 days and to my amazement making the match was relatively easy.

Mr. WORTLEY. Are those live-in?

Mr. BUCK. They stay 3 or 4 days, yes. Two people go for the 7 days. Our companions are just as important to us as the clients. The first 3 days we tell them it is on a trial basis. After we introduce them to the home and on the way home they may say, "I don't want to go tomorrow morning." So we go to trial two. After they go in and say, "yes, I will go there," then the coordinator visits them the next day to make sure things are OK.

The second day we make a personal visit and tell them the first 3 days it is a trial, and after 3 days if you say I would like to go back there, we say, that is your permanent place. It is simpler and yet more complex. It works well.

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We have a good feeling about the companions after we interview them and have many of them on hold because we haven't found a spot for them and all of a sudden we find the right home and give them a try. About 80 percent work on the first try. I would make a good cupid.

Mr. WORTLEY. Fascinating.

Mrs. Slater, what impact has the paperwork that Mrs. Heimer referred to a while ago—what impact does that have on the productivity of your staff?

Mrs. SLATER. Well, I couldn't agree more with Mrs. Heimer. It is very, very time consuming, and we have recently had many new staff members who are just orienting to public health and home care, and then to compound it to have very complex HCFA forms to complete on each patient.

They have to be recertified every 2 months, so there is often not only a 485 and a 486, but sometimes an addendum if we can't get all the information on the first two, so it is really very time consuming and certainly is having a significant impact on the amount of patients that the nurses can see in 1 day.

I would say that for many of the nurses it is taking approximately half their time to do the paperwork.

Mr. WORTLEY. HCFA's recordkeeping is almost as complex as the contemporaneous automobile records that the IRS is requesting. We will go to the audience and take 5 minutes of questions.

Ms. ODELL-HOLZER. I want to add on to what both of the home care people have mentioned. Not only are the 485's and 486's complicated, professional staff can deal with complexity. The problem is that each time a form goes in a different interpretation comes back on the same form, so it is not the complexity, it is the fact that the interpretation each time is different.

Those forms are quite difficult to deal with and when Dr. Davin talked earlier about the Medicare regulations, I can empathize with that very much. We are also in the middle.

Mr. WORTLEY. If I understand you correctly, if we could cons uct the bureaucracy in Washington, how to read the information on the forms——

Ms. ODELL-HOLZER. If they were consistent it would help tremendously.

Mr. WORTLEY. That is a good observation.

Mr. MEECH. I would think that these people that are taking care of their spouses or whatever—in a case like mine—that we would get some kind of tax incentive for the people that prefer to keep the loved ones at home. I don't believe there is any such thing.

Mr. WORTLEY. You make an excellent point and I can tell you that right now there is under consideration in the Congress putting together a tax credit for those who may keep older citizens in their own home or members of their own family. That is—that has been under consideration for quite some time now.

I regret to tell you there has been no affirmative action in that direction to get it passed, but it is under consideration and I rather expect when the members of the House Ways and Means Committee, who are bogged down with a number of other areas of taxation at this point, when they get a break they will direct some attention to that.

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I think that is probably one of the ways of the future toward generating more home health care. It is long overdue and I personally am most supportive of that concept.

Thanks for your observation and raising it here today.

Mr. TAMANY. I want to compliment the panel, particularly Madison County. I say this because the last 6 years in our family we have had some problems of health. We have a sister who will be 89 next month—who is bedridden—with oxygen constantly and with treatments.

Our nurses are so good over there I really appreciate the efforts that they are doing for her but it is important that we get more. Our family has contributed to the cost of keeping her home, and it has been unbelievable. That is why I would appreciate if anything could be done—for cost—to reimburse the families that are taking care of their loved ones.

Mr. WORTLEY. Even if it isn't a direct cost reimbursement but a tax credit, you will accept it anyway——

Mr. TAMANY. I will. Sitting home day in, day out with somebody is rough and my dear wife has been doing that for 6 years.

Mr. WORTLEY. I am well aware of your unique problem, Paul. I will take one more question from the audience if there is one. I don't see one and I would have to remind you that if you think it is important to have panelists or if you think it is important to have a chairman to preside over the meeting all of us pale in our responsibility compared to the stenographer who takes down all this data.

I assured her we would be done by 3:30 this afternoon, so she can keep her flight home. I want to thank all of you for the significant contribution you have made toward the enlightenment of the U.S. House of Representatives on one of the most critical issues of our time: home health care. I thank the panel and everyone for your participation today. You have been very generous with your time.

This hearing is now closed.

[Whereupon, at 3:30 p.m., the hearing was adjourned.]

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